PRINTED: 12/30/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    INTERPRETATION NUMBER   NVS3135AGC	Bureau	of Licensure and Ce	rtification					
ST PATRICK REST HOME 2  ST PATRICK REST HOME 2  A847 NEW YORK STREET  A8487 NEW YORK STREET  B PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OMNETICAL STREET  OMNETICAL STREET  TAG  OND PREFIX TAG  OND PREFIX TAG  OND PREFIX TAG  OND PREFIX TAG  OND PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  ONLY OND  Initial Comments  Surveyor: 27364  This Statement of Deficiencies was generated as a result of the annual State Licensure survey and complaint investigation survey conducted at your facility on 11/04/08.  This survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.  The facility was licensed as a ten (10) beds, Residential Facility for Groups which provides care to elderly or disabled persons, and/or persons with mental illnesses, Category I residents.  The census at the time of the survey was 10 residents.  The census at the time of the survey was 10 residents.  The census at the time of the survey was 10 residents.  The census at the time of the survey was 10 residents.  The census at the time of the survey was 10 residents.  The Hall brision shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	112		IDENTIFICATION NUM		A. BUILDIN		COMPLETED	
CAS	NAME OF P	ROVIDER OR SUPPLIER	1	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1170	4/2000
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Surveyor: 27364 This Statement of Deficiencies was generated as a result of the annual State Licensure survey and complaint investigation survey conducted at your facility on 11/04/08.  This survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.  The facility was licensed for 10 total beds. The facility was licensed as a ten (10) beds, Residential Facility for Groups which provides care to elderily or disabled persons, and/or persons with mental illnesses, Category I residents.  The census at the time of the survey was 10 residents.  Ten (10) of ten (10) resident files were reviewed.  Three (3) of three (3) employee files were reviewed.  There were no complaints investigated during the survey.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY	D BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE ORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE		
the survey.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  RECEIVED  JAN 1 5 2009  BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEYADA	Y 000	Surveyor: 27364 This Statement of It a result of the annucomplaint investigated facility on 11/04/08 This survey was concerned and a state Board The facility for Groups Nevada State Board The facility was liced Residential Facility care to elderly or dipersons with mental residents. The census at the tresidents. The (10) of ten (10) reviewed. Three (3) of three reviewed.	and State Licensure sation survey conducted using Nevalle (NAC) 449, Reside Regulations, adopted of Health on July from Groups which provided persons, and all illnesses, Category time of the survey was all of the survey	urvey and ed at your da ential d by the 14, 2006. ds. ovides //or / I as 10		p.o.c acceptal	NESIE	
LINE KUKWINI TERHIPANK RETICIONOLOS WORO		the survey.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.		strued as ations, ay be federal,		JA BUREAU OF LIK	N 1 5 2009 CENSURE AND CERTIFICATION	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

WHAT. WOMEN'S IRREPORTED IN 1975

STATEMENT OF DEFICIENCIE	s
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2)	MULTIPLE	CONSTRUCTION
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(X3) DATE SURVEY COMPLETED

NVS3135AGC

A. BUILDING
B. WING

11/04/2008

NAME OF PROVIDER OR SUPPLIER

ST PATRICK REST HOME 2

STREET ADDRESS, CITY, STATE, ZIP CODE

4847 NEW YORK STREET LAS VEGAS, NV 89104

	LAS VEGAS, NV 89104		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Continued From page 1	Y 000		
identified:			
449.196(1)(c) Qualifications of Caregiver- Read regulation	Y 067		
NAC 449.196 1. A caregiver of a residential facility must: (c) Understand the provisions of NAC 449.156 to 449.2766, inclusive, and sign a statement that he has read those provisions.		received copies, read, and	
This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/4/08, the facility failed to ensure that 2 of 3 caregivers read the provisions of NAC 449.156 to 449.2766 and signed a statement that he has read those regulations (#1 #3).  Findings:  Review of Employee #1's (date of hire 6/2004) and Employee #3's (date of hire 3/24/05) files		a binder at the facility along with the employees' signed statements (Attachm #1 & #2) indicating that they had read and comprehe NAC 449.156 to 449.2766. A new employees will be give a copy of the provisions tread and the facility will maintain their signed statements. The administra	ent nded 11 n o
revealed they lacked a signed statement indicating they had read NAC 449.156 to 449.2766.		c) 1-08-09	
Severity: 1 Scope: 3			
449.209(2) Health and Sanitation-Outside garbage	Y 172		5
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 identified:  449.196(1)(c) Qualifications of Caregiver- Read regulation  NAC 449.196  1. A caregiver of a residential facility must: (c) Understand the provisions of NAC 449.156 to 449.2766, inclusive, and sign a statement that he has read those provisions.  This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/4/08, the facility failed to ensure that 2 of 3 caregivers read the provisions of NAC 449.156 to 449.2766 and signed a statement that he has read those regulations (#1 #3).  Findings:  Review of Employee #1's (date of hire 6/2004) and Employee #3's (date of hire 3/24/05) files revealed they lacked a signed statement indicating they had read NAC 449.156 to 449.2766.  Severity: 1 Scope: 3  449.209(2) Health and Sanitation-Outside	Continued From page 1 identified:  449.196(1)(c) Qualifications of Caregiver- Read regulation  NAC 449.196 1. A caregiver of a residential facility must: (c) Understand the provisions of NAC 449.156 to 449.2766, inclusive, and sign a statement that he has read those provisions.  This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/4/08, the facility failed to ensure that 2 of 3 caregivers read the provisions of NAC 449.156 to 449.2766 and signed a statement that he has read those regulations ( #1 #3).  Findings:  Review of Employee #1's (date of hire 6/2004) and Employee #3's (date of hire 3/24/05) files revealed they lacked a signed statement indicating they had read NAC 449.156 to 449.2766.  Severity: 1 Scope: 3	(EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 identified:  449.196(1)(c) Qualifications of Caregiver- Read regulation  NAC 449.196  1. A caregiver of a residential facility must. (c) Understand the provisions of NAC 449.156 to 449.2766, inclusive, and sign a statement that he has read those provisions.  Y 067  a) Employees #1 and #3 hav received copies, read, and signed NAC 449.156 to 449.2766 and signed a statement that he has read those regulation of NAC 449.156 to 449.2766 and signed a statement that he has read those regulations (#1 #3).  Findings:  Review of Employee #1's (date of hire 6/2004) and Employee #3's (date of hire 3/24/05) files revealed they lacked a signed statement indicating they had read NAC 449.156 to 449.2766.  Severity: 1 Scope: 3  449.209(2) Health and Sanitation-Outside  Y 067  a) Employees #1 and #3 hav received copies, read, and signed NAC 449.156 to 449.156 to 449.156 to 449.156 to 449.156 to 449.156 to 449.2766.  A master copy of the provisions will be kept in a binder at the facility along with the employees' signed statements (Attachm #1 & #2) indicating that they had read and comprehe NAC 449.156 to 449.2766. A new employees will be give a copy of the provisions tread and the facility will maintain their signed statements. The administra will monitor for compliance copy of the provisions tread and the facility will maintain their signed statements. The administra will monitor for compliance copy of the provisions tread and the facility will maintain their signed statements. The administra will monitor for compliance copy of the provisions tread and the facility will maintain their signed statements. The administra will monitor for compliance copy of the provisions tread and the facility will maintain their signed statements. The administra will monitor for compliance copy of the provisions will be well to the provisions will be kept in a binder at the facility along with the employees will be copy of the provisions wi

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2)	MULTIPLE	CONSTRUCTION	

(X3) DATE SURVEY COMPLETED

NVS3135AGC

A. BUILDING \_\_\_\_\_\_\_B. WING \_\_\_\_\_

11/04/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST PATRICK REST HOME 2

4847 NEW YORK STREET LAS VEGAS, NV 89104

ST PATRICK REST HOME 2			AS, NV 891		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 172	Continued From page 2  NAC 449.209  2. Containers used to store garbage outs the facility must be kept reasonably clea must be covered in such a manner that are unable to get inside the containers. once each week, the containers must be and the contents of the containers must removed from the premises of the facility	an and rodents At least e emptied be	Y 172	Y172 a) The facility has purchas 2 new covered garbage conta and removed the containers without covers from the fac	iners
	This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation and interview, the facility failed to provide covered garbage containers outside the facility.  Findings include:  On 11/04/08 at 1:20 PM, 4 garbage cans were observed in the front yard without lids.  Interview  On 11/04/08 at 1:21 PM, Employee #1 reported he didn't know where the lids were for the garbage cans.  Severity: 2 Scope: 3  449.209(3) Health and Sanitation-Inside garbage			b) The facility will ensure the garbage containers are always covered by daily insupposed by the employees (Attachment 44). The employees and resivil be instructed to cover the containers after each the administrator will monifor compliance.  c) 1-10-09	spection of #3- dents of
Y 173			Y 173		
	NAC 449.209 3. Containers used to store garbage in the kitchen and laundry room of the facility recovered with a lid unless the containers in an enclosed cupboard that is clean an prevents infestation by rodents or insect	must be are kept nd			

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE	CONSTRUCTION
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(X3) DATE SURVEY COMPLETED

NVS3135AGC

A. BUILDING
B. WING

11/04/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST PATRICK REST HOME 2

4847 NEW YORK STREET LAS VEGAS, NV 89104

0.17.	LAS VEG	AS, NV 891	104	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 173	Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste.  This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation, the facility failed to provide covered garbage containers in the kitchen.  Findings include:  On 11/04/08 at 2:20 PM, 1 garbage can used for food waste was observed on the floor next to the dishwasher in the kitchen, without a lid.  Severity: 2 Scope: 3  449.209(4)(d) Health and Sanitation-Dirt, Garbage, Refuse	Y 173		d iner
	NAC 449.209  4. To the extent practicable, the premises of the facility must be kept free from: (d) Accumulations of dirt, garbage and other refuse.  This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/4/08, the facility's heating air conditioning (HVAC) ceiling return			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NVS3135AGC

A. BUILDING \_\_\_\_\_ B. WING \_\_\_\_\_

11/04/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ST PATRICK REST HOME 2** 

4847 NEW YORK STREET LAS VEGAS, NV 89104

	LAS VEG	AS, NV 891	104	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 177	Continued From page 4 grills had accumulations of dirt. Findings include: The ceiling HVAC return grill compartments in the central hallway and living area had large accumulations of dust and dirt.	Y 177	Y177 a) The facility has cleaned the ceiling HVAC return gri compartment as well as the ceiling fans and all air duct grills. b) The employees will replacair filters every 3 months,	e
Y 179	Severity: 2 Scope: 3  449.209(6) Health and Sanitation-Screens  NAC 449.209 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects.	Y 179	clean the grills as needed, and ceiling fans and air du grills will be checked and cleaned as needed monthly. The employees ans residents will be asked to clean and maintain all grills, filter and ceiling fans. The administrator will monitor for compliance.	ct
	This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/04/08, the facility failed to have a screen to prevent the entry of insects on 1 of 7 windows.  Findings include:  During a facility tour on 11/04/08 at 1:15 PM, the window in Bedroom #5 was observed without a screen to prevent insects from entering the facility.  Severity: 2 Scope: 1		C71-10-09	
Y 899	449.2744(2) Medication Administration	Y 899		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau	<u>of Licensure and Ce</u>	rtification				I ORIVI	AFFINOVI	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	MBER: A. BUILDING _				DATE SURVEY COMPLETED	
		NVS3135AGC		B. WING _		11/0	4/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
ST PATE	RICK REST HOME 2	`		V YORK ST AS, NV 891				
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Y 899	Continued From pa	age 5		Y 899			Ì	
Į.	NAC 449.2744							
		or of the facility shall	keen a		Y179			
	2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which				a)The facility has p	purchase	P.d	
- 5					a new window screen			
		s responsible for assi			bedroom #5 and has r	eplaced	i i	
		of medication to a re			the old screen that			
	This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified				recently damaged fro	m the		
3					weather.			
10					b) The employees will	check		
=	from this indication				all windows monthly		ire	
()					that they are capabl			
91					being opened as well		perly	
13					screened (Attachment			
					#8). The employees a will be asked to cle		laents	
3					maintain all windows		h v	
8	This Regulation is	not met as evidence	d by:		malfunctions will be		1 -	
),	This Regulation is not met as evidenced by: Surveyor: 27286				immediately. The adm	uinistra	tor	
					will monitor for com	ıpliance	<b>+</b> •	
		and record review the			c)1-10-09			
9		it a log was kept of c ster medications that						
- 3		egivers were respon					5 (	
		ninistration of medica						
- 8	resident.						[	
	Findings include:						Action and action a	
	Interview:							
1	Employee #1 indica	ated that initials on th	ne					
	medication administration record (MAR) was							

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and initials.

Record review:

Employee #1's but the employee could not produce a log to show a copy of his signature

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11/04/2008

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING
	NIVERAGEAGG	B. WING

(X3) DATE SURVEY COMPLETED

NVS3135AGC

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER ST PATRICK REST HOME 2

**4847 NEW YORK STREET** 

		LAS VEGAS, NV 89	<del>3</del> 104	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION	JLL PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	BE COMPLETE
Y 899	Continued From page 6	Y 899		
	Initials were on the MAR of each resident' but there was no indication of which initial belonged to which employee.  Severity: 1 Scope: 3  449.2742(1)(a-c) Medication Administration NAC 449.2742  1. The administrator of a residential facility provides assistance to residents in the administration of medications shall:  (a) Ensure that a physician, pharmacist or registered nurse who does not have a final interest in the facility:  (1) Reviews for accuracy and appropriateness, at least once every 6 more the regimen of drugs taken by each residenthe facility, including, without limitation, and over-the-counter medications and dietary supplements taken by a resident; and  (2) Provides a written report of that rever the administrator of the facility;  (b) Include a copy of each report submitted the administrator pursuant to paragraph (a) file maintained pursuant to NAC 449.2749 resident who is the subject of the report; are (c) Make and maintain a report of any actions that are taken by the caregiver employed by the facility in response to a resubmitted pursuant to paragraph (a).	rs files as siles as	a) The Administrator will keep a log of caregivers assigned to administer medication that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication toaa resident.  b) The Medication Administration Record (MAR) will be checked by the employees and initialedafter assisting with the administration of medication on each shift daily. The facility will require that each time that medication is dispensed by an employee, that employee must initial the (MAR). The Administrator will mon itor for compliance.  c) 1-10-09	

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Bureau	of Licensure and Co	rtification				PRINTE FORM	D: 12/30/2008 A APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF	PD 0.10	NVS3135AGC		B. WING		11/04/2008	
	PROVIDER OR SUPPLIER				(, STATE, ZIP CODE		0-11/2-000
ST PAI	RICK REST HOME 2	1	LAS VEG	V YORK S AS, NV 89	1REET 9104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		FILL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETE DATE
YA870	Continued From page	ge 7		YA870	DEFICIENCY)		
	This Regulation is a Surveyor: 27286  Based on record reversiled to ensure that was performed by a registered nurse at a for 7 of 10 residents longer than six months. Findings include:  Resident #1 admitted. Two medication proferecord dated 4/08/07. Resident #2 admitted. One medication proferecord dated 10/18/07. Resident #3 admitted. One medication proferecord dated 10/18/07. Resident #4 admitted. Two medication profirecord dated 3/20/07. Resident #5 admitted. Two medication profirecord dated 3/20/07. Resident #6 admitted. Two medication profirecord dated 3/16/07. Resident #6 admitted. Two medication profirecord dated 3/16/07. Resident #7 admitted.	riew on 11/04/08, the a medication profile physician, pharmac east once every six residing in the faciliths.  In the facility on 4/ille reviews available in the facility on 5/ille review available in the facility on 7/ille review available in the facility on 9/2 ille review available in the facility on 9/2 ille reviews available and 10/10/08.  In the facility on 10 ille reviews available and 10/15/08.  In the facility on 2/0 ille reviews available and 10/15/08.  In the facility on 2/0 ille reviews available and 10/15/08.  In the facility on 2/0 ille reviews available and 10/17/08.	e facility review ist or months ty for 109/02. In the 12/04. In the 101/05. In the 108/07. In the 108/07. In the 108/07.	YA870	YA870 a) The facility has out a Medication Revresidents I through ensure their next rewill be performed. b) The Administrator evaluate bhe resident files monthly to updatheir medical review, ds as needed and review as as needed and review each resident file to maintain what is incompleted the maintain what is incompleted to review ments monthly to updamedication review/recompliance. c) 1-10-09	iw for 7 to views will ts' ate /recor be made or docu ate the cord.	
Resident #7 admitted to the facility on 3/10/07. Two medication profile reviews available in the record dated 4/23/07 and 10/10/08.		0/07. in the					

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PRINTED: 12/30/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS3135AGC 11/04/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4847 NEW YORK STREET** ST PATRICK REST HOME 2 LAS VEGAS, NV 89104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) YA870 Continued From page 8 YA870 Severity: 2 Scope: 3 YA890 449.2744(1)(a) Medication/Receipt Log YA890 YA890 a() A log for medication /receipt has been maintain NAC 449,2744 ed at the facility but was 1. The administrator of a residential facility that misfiled during the time of provides assistance to residents in the the survey. administration of medication shall maintain: (a) A log for each medication received by the The facility will inst facility for use by a resident of the facility. The ruct the employees to keep log must include: a log of all incoming medi (1) The type and quantity of medication cation and to keep it in a received by the facility; marked binder for easy acc (2) The date of its delivery: essibility. Monthly review (3) The name of the person who accepted s will be performed by the the delivery: facility. The Administrat (4) The name of the resident for whom the or will monitor for compli medication is prescribed; and ance. (5) The date on which any unused medication is removed from the facility or destroyed. C) 1-10-09 This Regulation is not met as evidenced by: Surveyor: 27286 Based on observation and interview the facility failed to maintain a log for each medication received by the facility for use by the residents. Findings include: Interview:

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Employee #1 indicated that there was no log or information kept regarding the medications that

were received for each resident.

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If continuation sheet 9 of 14

record (MAR) was accurate for 10 of 10

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by:

Based on record review and interview, the facility failed to ensure the medication administration

Surveyor: 27286

If continuation sheet 10 of 14 JAN 1 5 2009

initial the (MAR) as medic ation is dispensed to the

or will monitor for compli

The Administrat

resident.

c) 1-10-09

ance.

WPS011

Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS3135AGC 11/04/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

ST PATRICK REST HOME 2

4847 NEW YORK STREET LAS VEGAS, NV 89104

L	LAS	LAS VEGAS, NV 89104				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE PATE		
YA895	Continued From page 10	YA895				
	Continued From page 10 residents.  Findings include:  Record Review:  The MAR of 10 of 10 residents failed to show which medications were given for the morning and afternoon doses on 11/04/2008.  Interview:  Employee #1 indicated that he initials the MAR for each resident at one time in the evening at giving the night time medications to the resident Severity: 1 Scope: 3  449.2749(1)(a-j) Resident File  NAC 449.2749  1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related the resident, including without limitation:  (a) The full name, address, date of birth and social security number of the resident.  (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him.	Refter ent. YA930	YA930 a) Residents #1, #2, #3, #4, #5, #6, #7, and #9 all maintained their initial and annual ADL assessments; however, during the time of the survey they were misfiled. Each resident now has their ADL assessments in their files. All residents are up to date on their initial and an nual physical exams; however, during the time of the survey they were misfiled. Each resident now now has their physicals in their files. Resident #5 had a negative result on his 2-step TB test performed and read on 1-12-09 by Dr. Jonathan Reboton.  b) The Administrator will ensure that every resident admitted in the facility will be required to have a complete initial and annual physical exam, an initial and annual physical exam, an initial and annual TB screenings. Notifications posted on a bulletin board stating physical exams, ADL assessments			
4	(c) A statement of the resident's allergies, if ar	ny,	, and TB screenings will	 		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM

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Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS3135AGC 11/04/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4847 NEW YORK STREET** ST PATRICK REST HOME 2 LAS VEGAS, NV 89104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG DEFICIENCY**) YA930 Continued From page 11 YA930 and any special diet or medication he requires. serve as reminders so res-(d) A statement from the resident's physician idents do not miss their concerning the mental and physical condition of annual evaluations. the resident that includes: bulletin board will be held (1) A description of any medical conditions at the facility office to which require the performance of medical prevent employees from services: forgetting to obtain and (2) The method in which those services must perform these annual tasks be performed; and The Administrator will mon-(3) A statement of whether the resident is itor for compliance. capable of performing the required medical services. Attachment #9 through #25: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations Resident #1 has a current adopted pursuant thereto. ADL (Attachment #9). (f) The types and amounts of protective Resident #2 has an initial supervision and personal services needed by the and current ADL (Attachmeresident. nt #10 and #11). (g) An evaluation of the resident's ability to Resident #3 has an initial perform the activities of daily living and a brief description of any assistance he needs to and current ADL (Attachmeperform those activities. The facility shall nt #12 and #13). prepare such an evaluation: Resident #4 has a current (1) Upon the admission of the resident: physical exam and initial (2) Each time there is a change in the mental and current ADL (Attachmeor physical condition of the resident that may nt #14, #15, and #16). significantly affect his ability to perform the Resident #5 has an initial

vendors and medical professionals that provide services for the resident.

by the administrator of the facility and the

resident or a representative of the resident.

(i) The name and telephone number of the

activities of daily living; and

(j) A document signed by the administrator of the facility when the resident permanently leaves the facility.

(3) In any event, not less than once each

(h) A list of the rules for the facility that is signed

Resident #7 has a current physical exam and an initial and current ADL (Attac hment #22, #23, and #24).

and current ADL and a cur-

rent 2-step TB screening (Attachment #17, #18, and

Resident #6 has a current

physical exam and a curre-

nt ADL (Attachment #20 and

#19).

#21).

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies STATE FORM WPS011

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Bureau	of Licensure and Ce	rtification					: 12/30/200 APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPP IDENTIFICATION I		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER	A. BUILDII	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS3135AGC		B. WING_		11/04/2		
NAME OF F	PROVIDER OR SUPPLIER		1		STATE, ZIP CODE			
ST PATE	RICK REST HOME 2			V YORK ST AS, NV 891				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ACTION OF TH	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
YA930	Continued From page 12			YA930		İ	<u> </u>	
	This Regulation is not met as evidenced by: Surveyor: 27286				Resident #9 has an ADL (Attachment #2			
	Based on record review, the facility failed to complete initial and/or annual physicals and activities of daily living (ADL) assessments, and TB screenings for 8 of 10 residents. (#1; #2; #3; #4; #5; #6; #7 & #9)							
	Findings include:							
	Record review:							
	Resident #1 - admission date 4/09/02, last physical 1/27/06; no documentation of an annual ADL assessment in file.							
·	Resident #2 - admission date 5/12/04, only physical in file dated 4/14/08; no documentation of an initial or annual ADL assessment in file.							
	Resident #3 - admissiphysical in file dated of an initial or annua	l 5/30/08; no docume	entation					
ļ	Resident #4 - admiss physical; no docume	sion date 9/26/06, no entation of an initial o	o annual or annual					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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ADL assessments in file.

results in file.

Resident #5 - admission date 10/25/06, no documentation of an initial or annual ADL assessment in file; no 2 -step TB screening

Resident #6 - admission date 2/08/07, no documentation of an initial or annual physical in

file; no documentation of an annual ADL

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Bureau of Licensure and Certification					FORM	M APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVS3135AGC		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED			
NAME OF	PROVIDER OR SUPPLIER	14433135AGC	STREET ADD			11/	04/2008
	RICK REST HOME 2		4847 NEW	YORK S	Y, STATE, ZIP CODE STREET		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
YA930	assessment in file.  Resident #7 - admis documentation of ar file; no documentation assessment in file.  Resident #9 - admis documentation of ar file.  Repeat deficiencies	ssion date 3/10/07, n n initial or annual phy on of an initial or and sion date 7/16/08, no n initial ADL assessm	o ysical in nual ADL o nent in	YA930	DEFICIENCY		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. WPS011

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